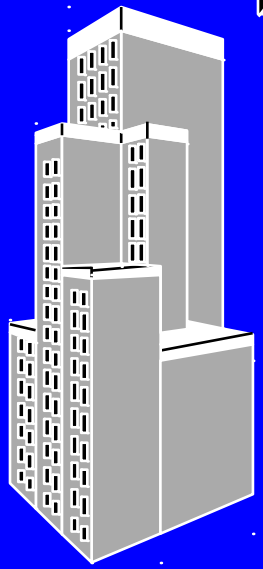
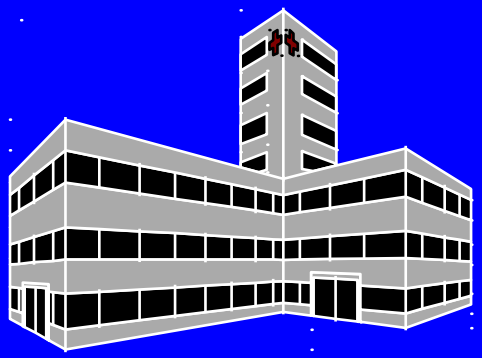
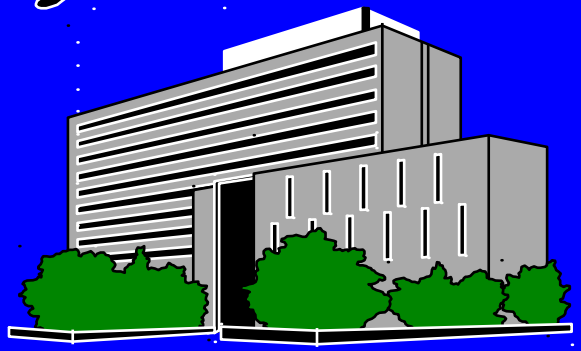
Comparative Healthcare Systems







Uniform Services University of Health Sciences

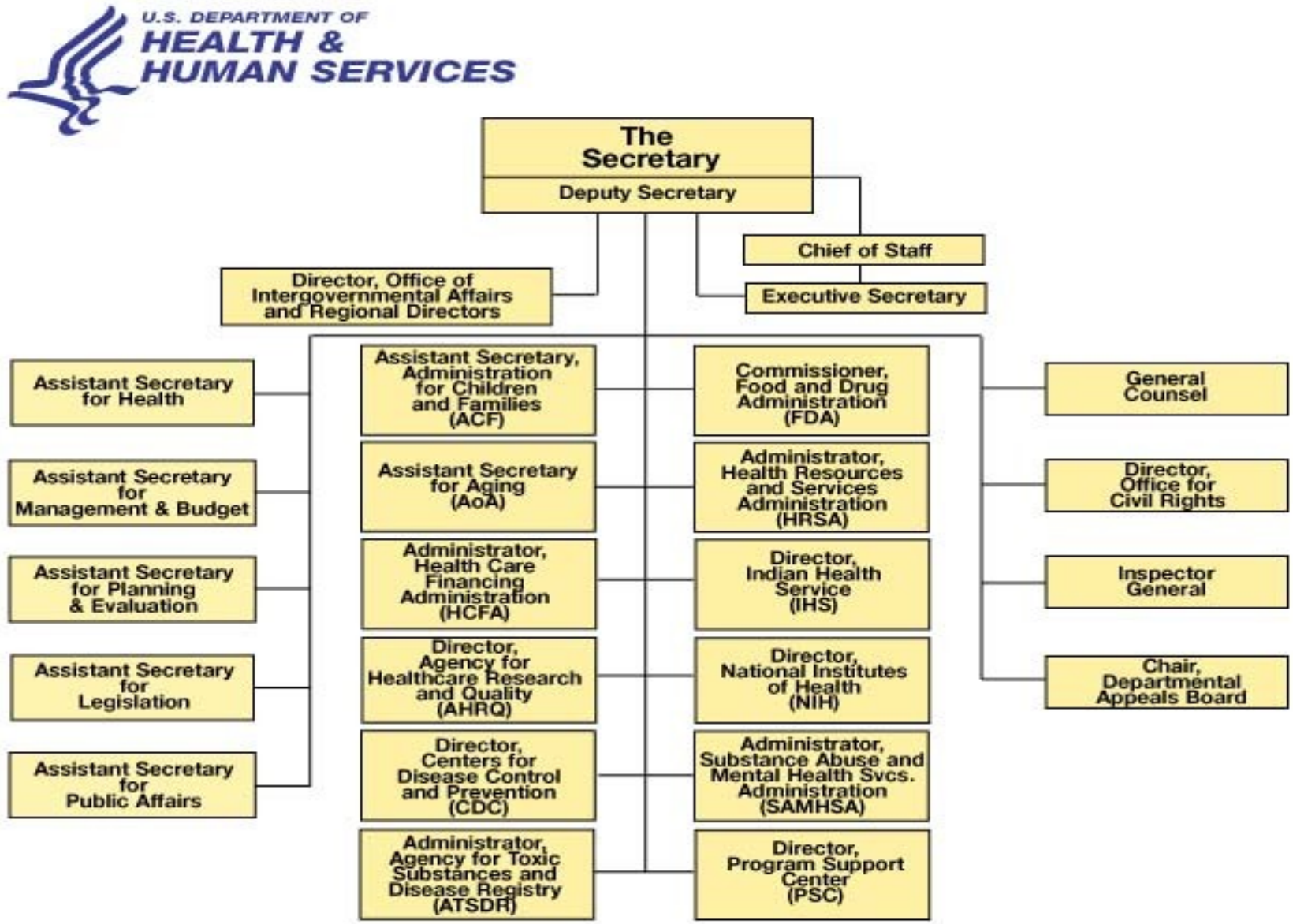
Bethesda, Maryland
September 19, 2002

AHRQ

Characteristics of AHRQ

- Research, not regulatory
- Health services research
- Evidence-based
- Grants, contracts

ORGANIZATIONAL CHART


U.S. DEPARTMENT OF
HEALTH &
HUMAN SERVICES
The Secretary
Deputy Secretary
Chief of Staff
Executive Secretary
Director, Office of Intergovernmental Affairs and Regional Directors
Assistant Secretary for Health
Assistant Secretary for Management & Budget
Assistant Secretary for Planning & Evaluation
Assistant Secretary for Legislation
Assistant Secretary for Public Affairs
Assistant Secretary, Administration for Children and Families (ACF)
Assistant Secretary for Aging (AoA)
Administrator, Health Care Financing Administration (HCFA)
Director, Agency for Healthcare Research and Quality (AHRQ)
Director, Centers for Disease Control and Prevention (CDC)
Administrator, Agency for Toxic Substances and Disease Registry (ATSDR)
Commissioner, Food and Drug Administration (FDA)
Administrator, Health Resources and Services Administration (HRSA)
Director, Indian Health Service (IHS)
Director, National Institutes of Health (NIH)
Administrator, Substance Abuse and Mental Health Svcs. Administration (SAMHSA)
Director, Program Support Center (PSC)
General Counsel
Director, Office for Civil Rights
Inspector General
Chair, Departmental Appeals Board

AHRQ Strategic Plan Goals

- **Goal 1:** Support improvements in health outcomes
- **Goal 2:** Strengthen quality measurement and improvement
- **Goal 3:** Identify strategies to improve access, foster appropriate use, and reduce unnecessary expenditures

AHRQ's Customers and Decisionmaking Levels

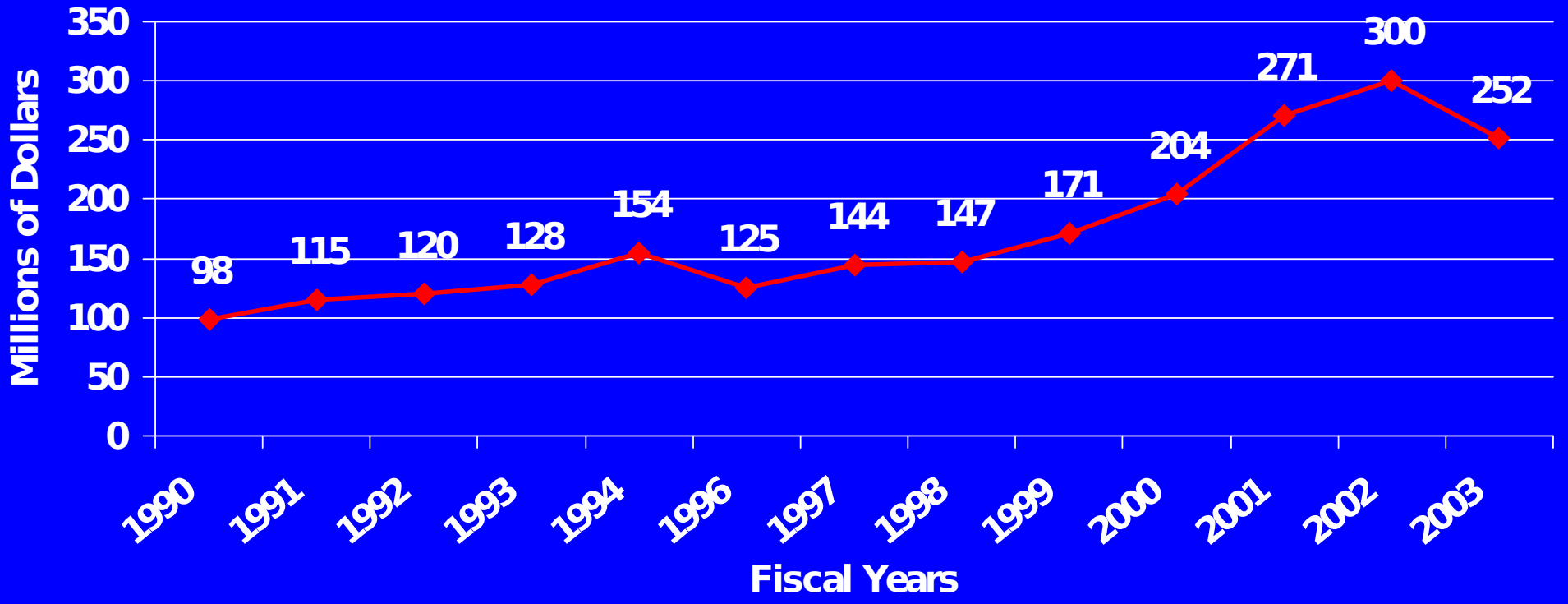
Clinical Policy Decisionmakers

Health Care Systems Decisionmakers

Public Policy Decisionmakers

FY 1990 – FY 2003 Appropriation History

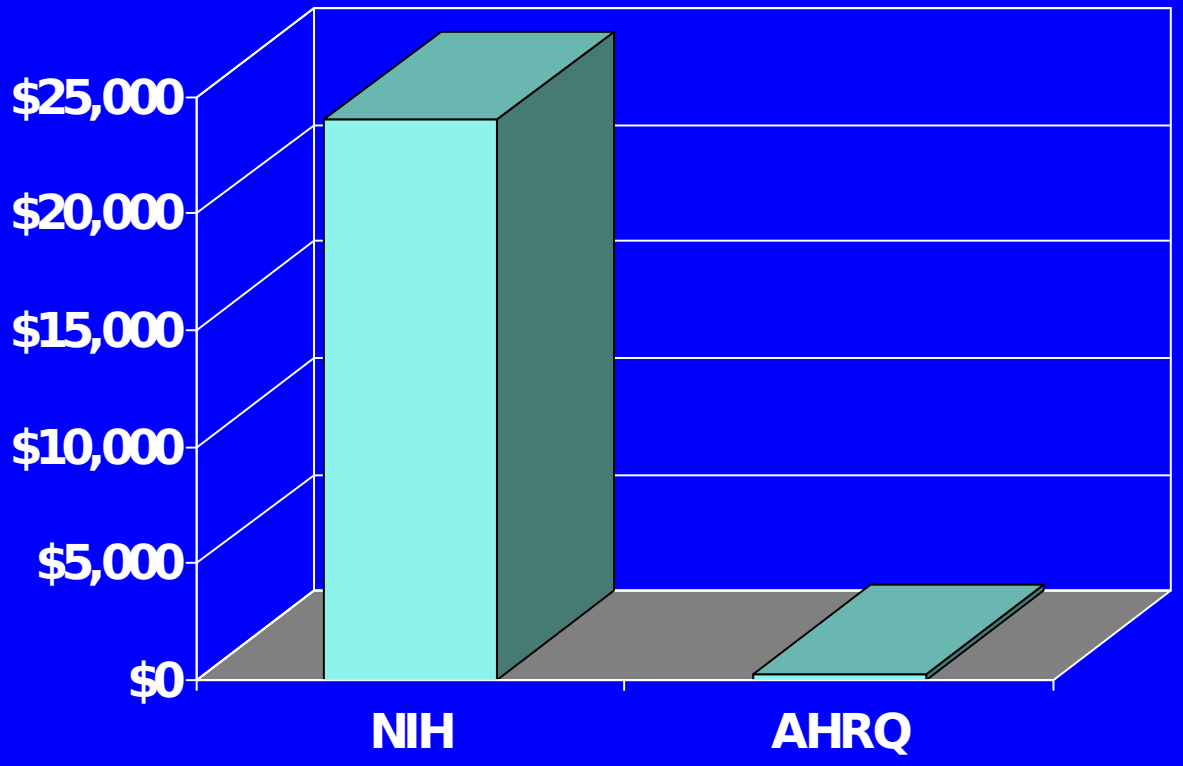
($ in Millions)



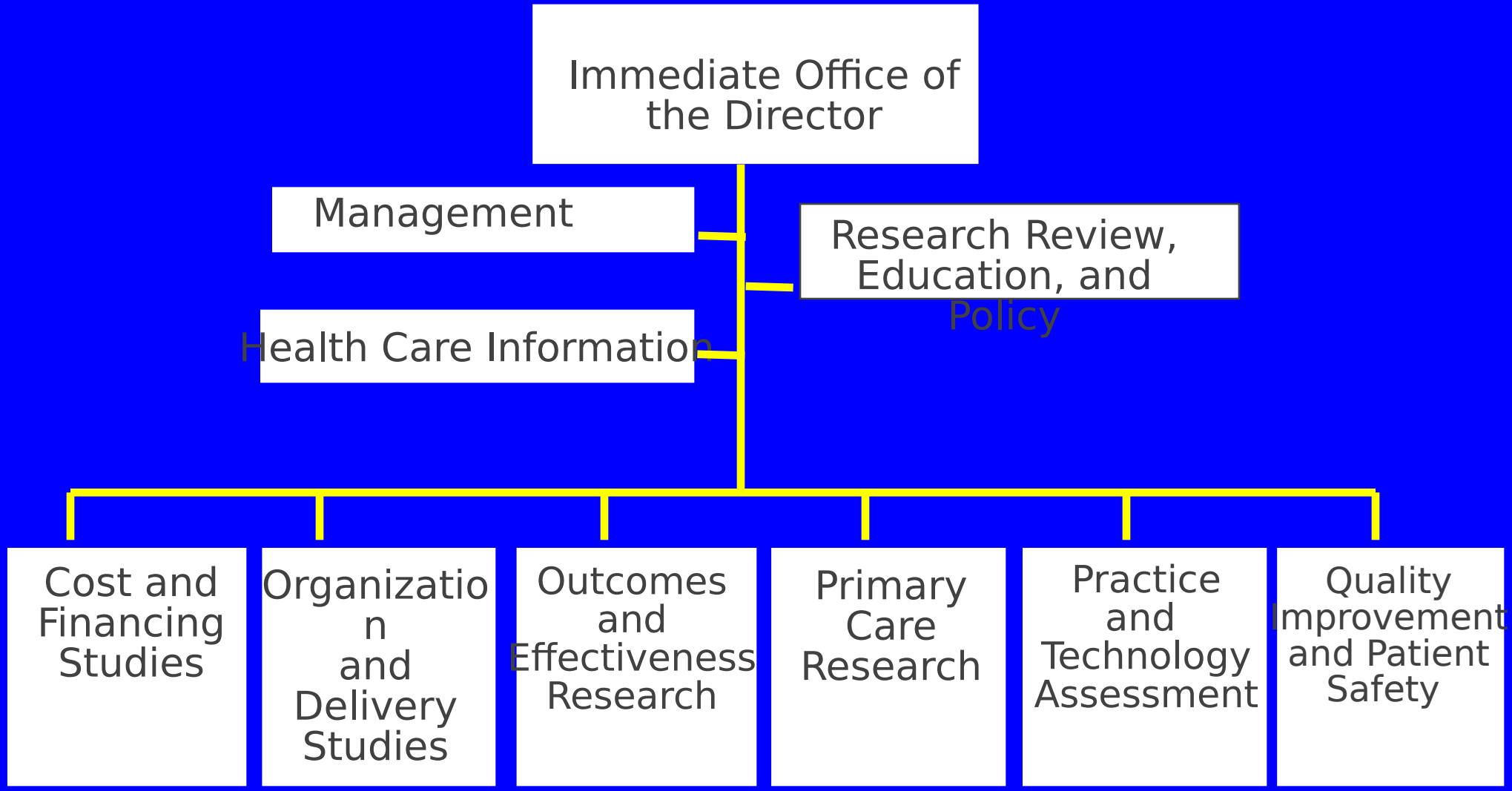
AHRQ

Reality Check

$ (Millions) Of Funding In FY02 Budget



Agency for Healthcare Research and Q



"What we really want to get at is not how many reports have been done, but how many people's lives are being bettered by what has been accomplished. In other words, is it being used, is it being followed, is it actually being given to patients?... [W]hat effect is it having on people?"

Congressman John Porter, 1998
Chairman, House Appropriations Subcommittee on Labor, HHS, and Education

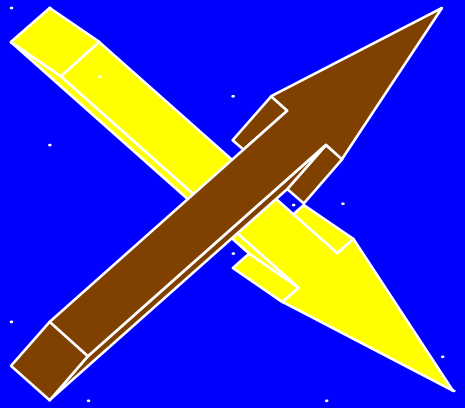
Bases for Comparison

- *Structure*: How is the system structured in terms of financing, delivery, and economic incentives?
- *Process*: How is care delivered? who does what to/for whom?
- *Outcomes*: What are the consequences of the system?

The Spectrum of Healthcare Systems

- single payor
- social insurance
- regulated market
- free market

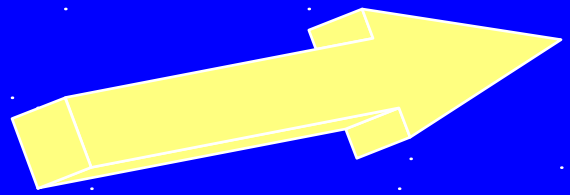
SUPPLY SIDE
REGULATION

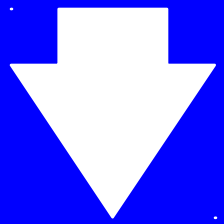


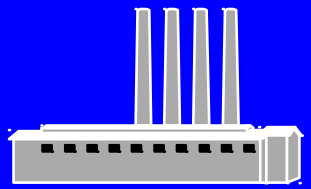
DEMAND SIDE
COMPETITION

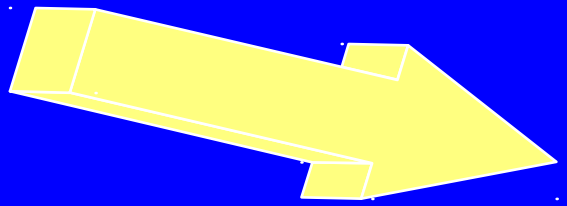
AHRQ

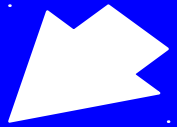
U.S. Healthcare System
Indemnity Based

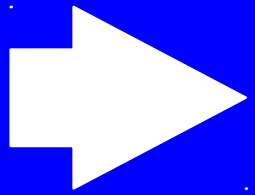


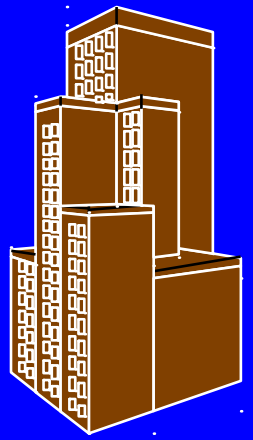


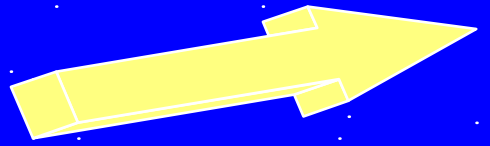


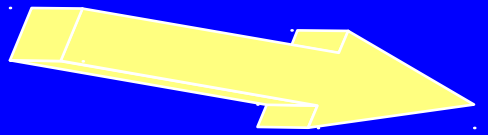


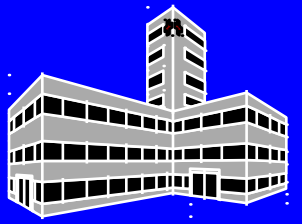








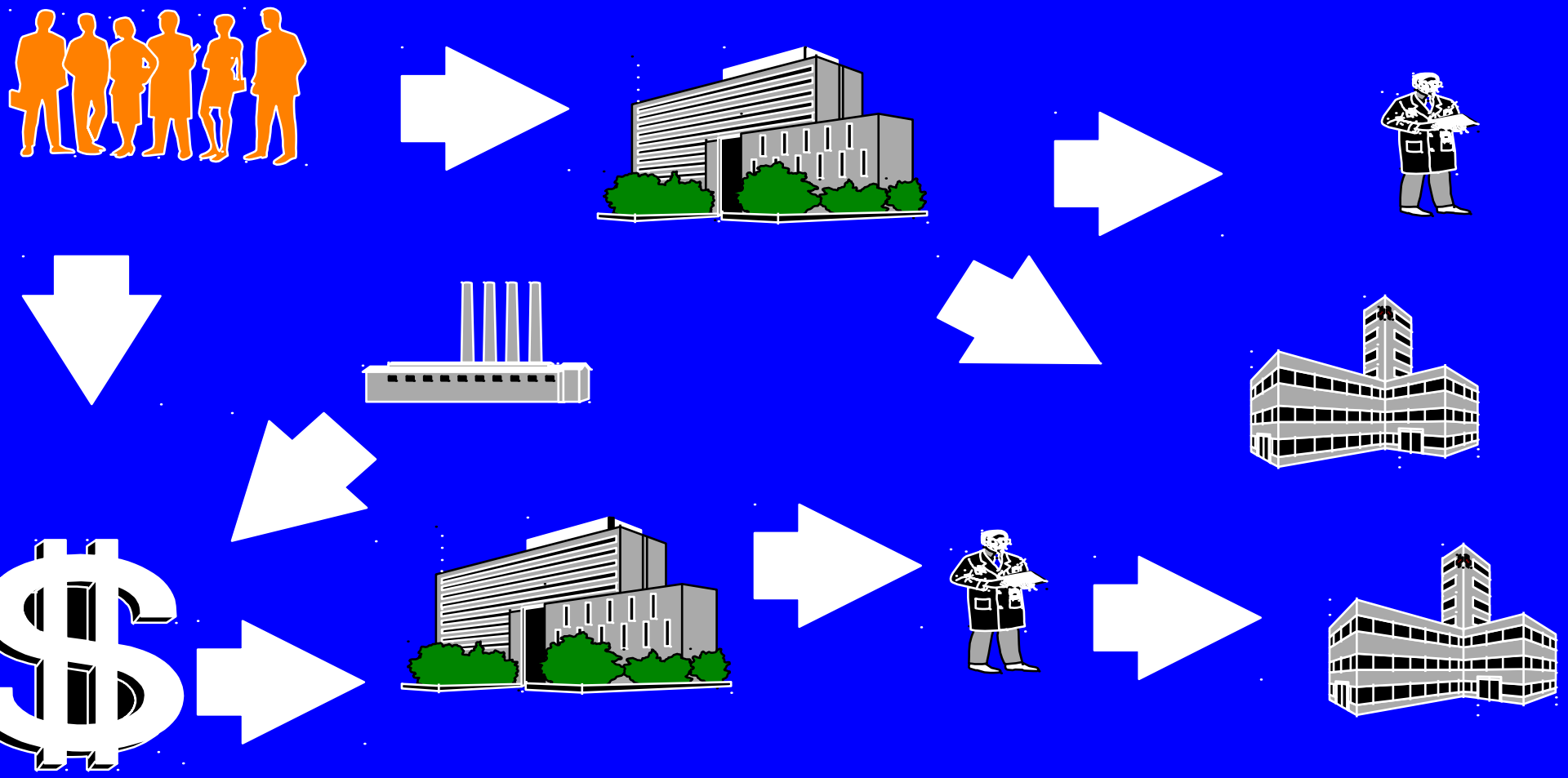




AHRQ

U.S. Medicare/Medicaid

U.S. Managed Care



Financing Healthcare Systems

- Out-of-pocket payment
- Individual private insurance
- Employment-based group private insurance
- Government financed

Out-of-Pocket Payments

- Direct purchase of services through the mid-1950s

- Challenge
  - unpredictable
  - medical costs exceed budget
  - knowledge deficit
  - physician selects service

Individual Private Insurance

- European tradition did not exist in US
- Early 1900's Metropolitan Life and Prudential companies insured workers
  - Administratively expensive
  - Never got a foothold

Employment-based Private Insurance

Factors in Development:

- Efficiency and rising costs of hospital care
- Profession driven
  - AHA established Blue Cross plans
    - Controlled industry by 1940
  - Blue Shield plans developed by state medical societies
- WWII competitive labor market

Government Financing

- Medicare
  - Part A Social Security System
  - Part B General revenues and premiums
- Medicaid
  - Federal/State financing

Health Care Financing in 1998

Type of Payment Healthcare	% Personal
→ Out-of-pocket payment	18%
→ Individual private insurance	3%
→ Employment-based private insurance	35%
→ Government financing	44%
Total	100%

Health Affairs 2000;19(4):188

Health Affairs 2001;20(2):193

AHRQ

Health Care Financing in 1998

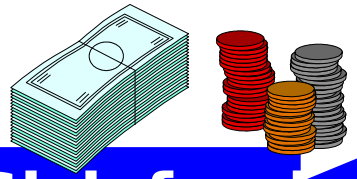
Principal Source of Coverage	% of Population
Uninsured	16%
Individual private insurance	4%
Employment-based private insurance	57%
Government financing	23%
Total	100%

Health Affairs 2000; 19(4):188

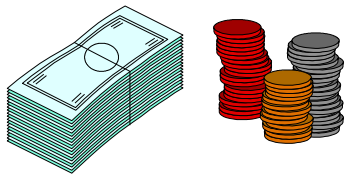
Health Affairs 2001;20(2):193

AHRQ

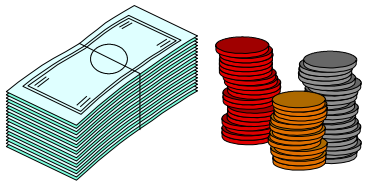
German Healthcare System



Sick funds



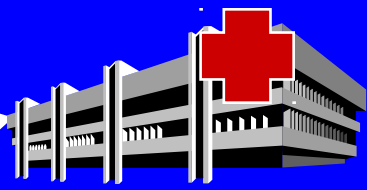
Sick funds



Sick funds

Concerted Action at the regional level

Regulated rates



Hospitals

Expenditure cap

Physician associati

AHRQ

Germany

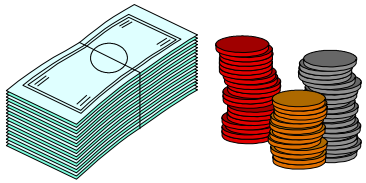
- **Health Insurance**
  - 1883 law required health care insurance
  - 500 Sick Funds
  - no exclusions;modest co-payments
  - social insurance & public assistance
- **Medical Care**
  - primary care (55%) and specialists (45%)

Germany

- Payment to Physicians & Hospitals
  - Sick Funds pay physicians associations which establish fee scale
  - Similar to DRG for hospitals and specialists
- Cost Controls
  - 1977 Cost Containment Act
  - Sick Fund competition
  - Social values of social solidarity and fairness

AHRQ

The National Health Service: Traditional Model

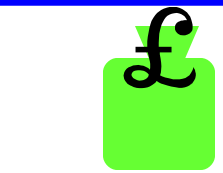


General taxes

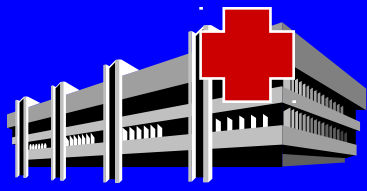
National Health Service

Global budget

Salary

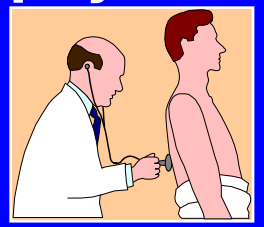


Capitation



Hospitals

Specialist physicia



General physician

AHRQ

United Kingdom

- **Health Insurance**
  - 1911 complex system similar to Germany
  - 1942 Sir William Beverage: National Health Service (NHS)
  - Health insurance is ***not*** employment based
  - 82% taxes; 13% employer-employee contributions; private insurers allowed

- **Medical Care**
  - Primary care is gatekeeper; consultants practice in hospitals
  - Hospitals are regionalized
  - Home care is highly developed

AHRQ

United Kingdom

- **Payment to Physicians & Hospitals**
  - Primary physicians are capitated; some fee-for-service for additional services
  - Specialists are employees of NHS
- **Cost Controls**
  - NHS caps payments
  - NHS limits the number of specialist
  - supply of personnel and facilites and budget for medical resources

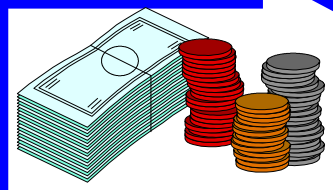
United Kingdom

- **Recent Reforms**
  - Shift funding based on hospital performance
  - Accountability for quality
  - Must be members of single local primary care group
  - Planning for population needs and improving quality

New Directions in the UK

- **Clinical governance**
  - shift from financing to clinical mechanisms
- **New regulatory bodies**
  - NICE
  - NPSA
  - CHI

UK Healthcare System: Recent reforms



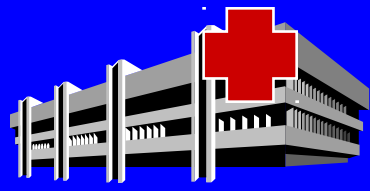
General taxes

National Health Service

Global budget

District health authorities

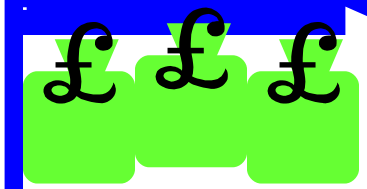
Negotiated contract



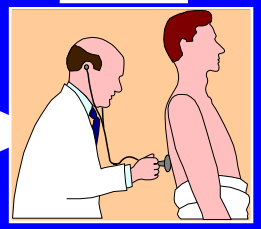
Hospitals

Negotiated contract

Specialist physicians



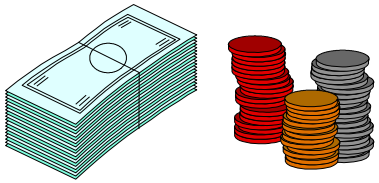
Expanded capitation



General physician

AHRQ

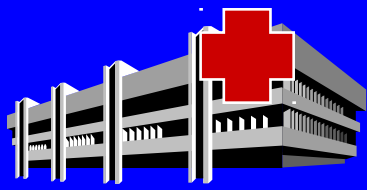
Canadian Healthcare System



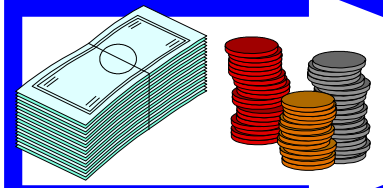
General taxes

Provincial Health Plan

Global budget



Hospitals



Fee for Service

Specialist and primary care physicians

AHRQ

Canada

- **Health Insurance**
  - 1947 Saskatchewan publicly financed universal hospital services insurance; 1963 physician services
  - Provincial, single payor
  - Federal pays 22%; provinces finance via taxes
  - ***Not*** employment based
  - Prohibition on private health insurance for services covered by provinces

- **Medical Care**
  - Primary care (55%) and specialists (45%)
  - Specialists receive higher payment via referral
  - High tech procedures are regionalized; wait lists for some specialized elective procedures

AHRQ

Canada

- **Payment to Physicians & Hospitals**
  - Physicians are paid fee-for-service negotiated by provincial governments and medical associations
  - Hospitals negotiate a global budget
  - No itemized bills; lower administrative costs

- **Cost Controls**
  - More LOS; more services; less cost
  - administrative costs; intensity of services; physician fees and pharmaceuticals

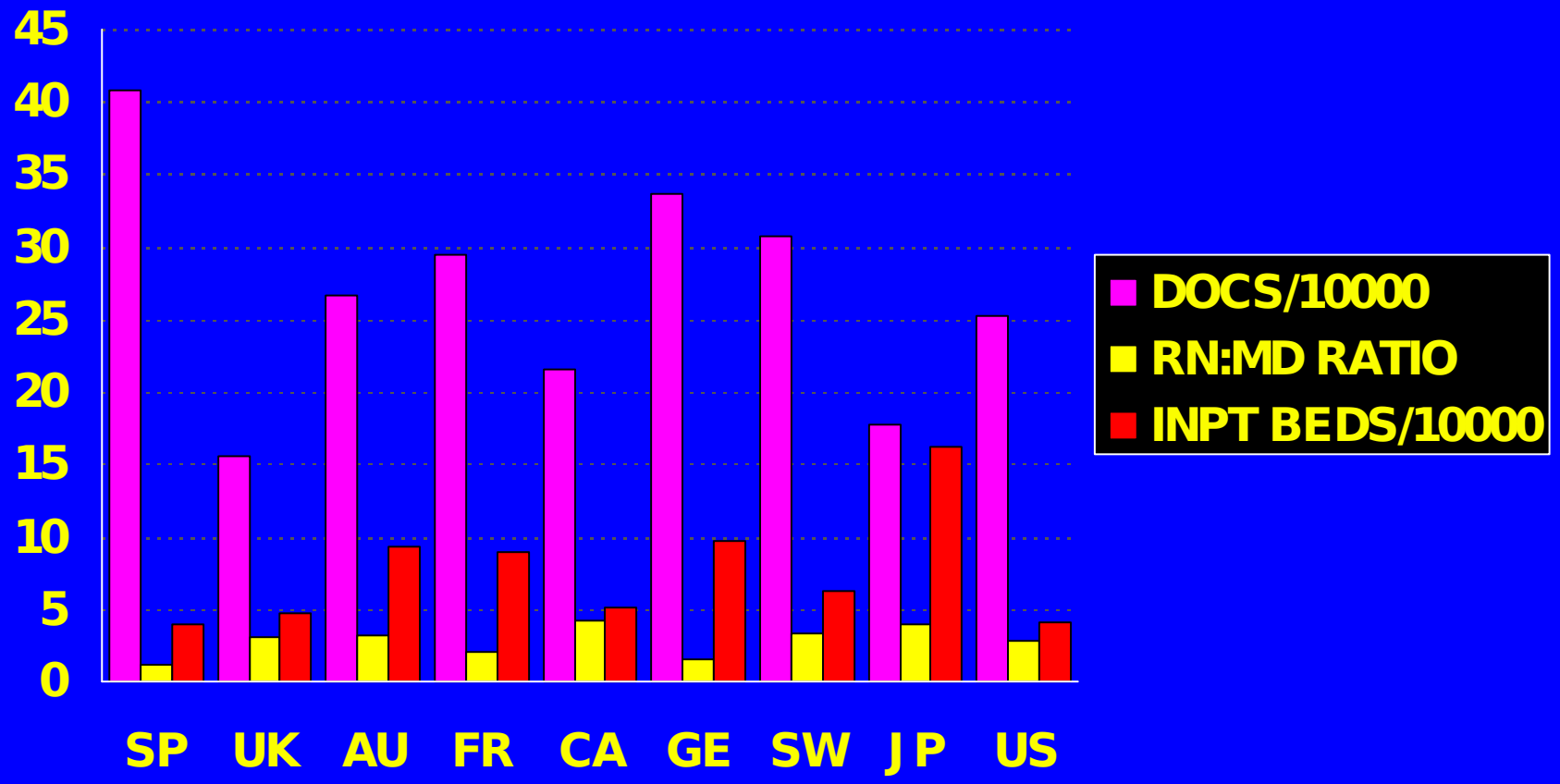
AHRQ

Conceptual Framework

- *Equity*: the "fairness" of the system; is there universal access?
- *Efficiency*: what is the "bang for the buck" and is it maximized?
- *Outcomes*: what are the results achieved by the health system?
- *Choice*: how much freedom is there in choice of service and provider?

Comparative Health Systems

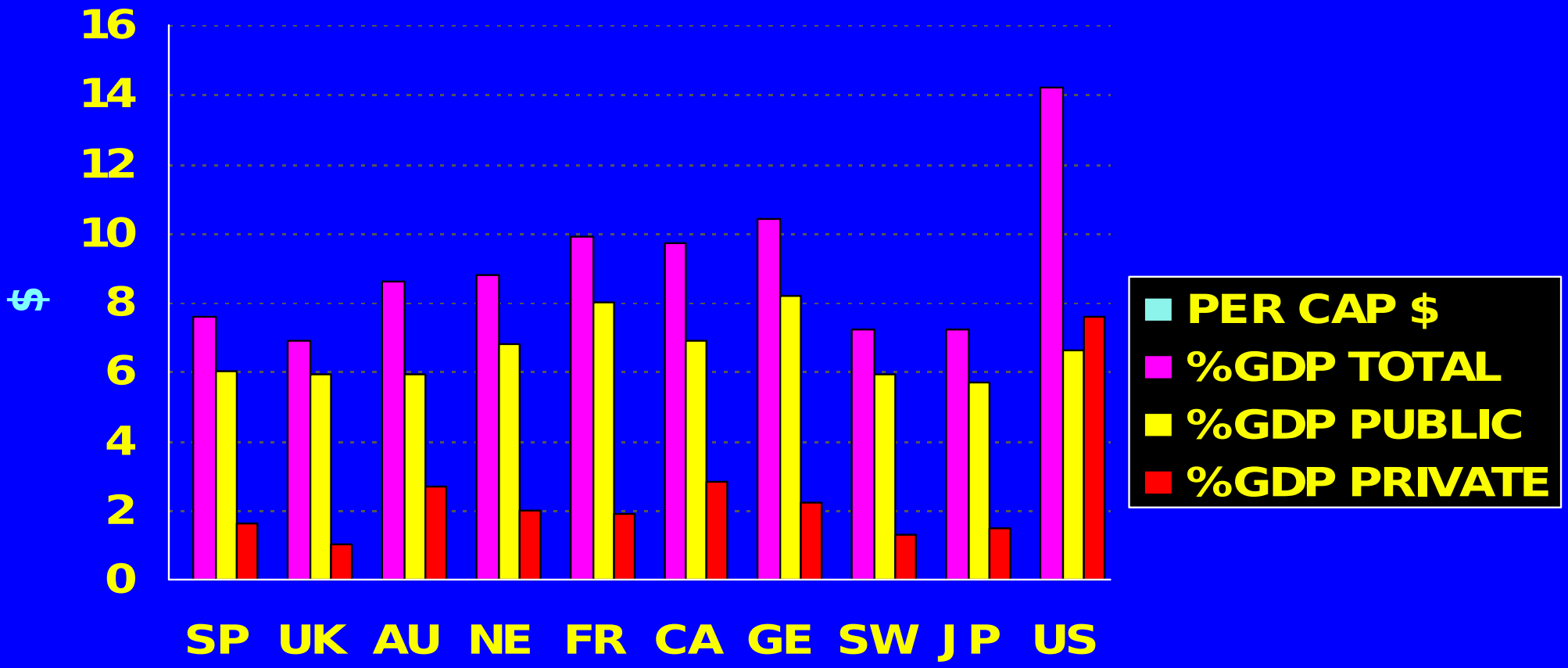
Inputs



OCED HEALTH DATA 97

AHRQ

Comparative Health Systems
Expenditures

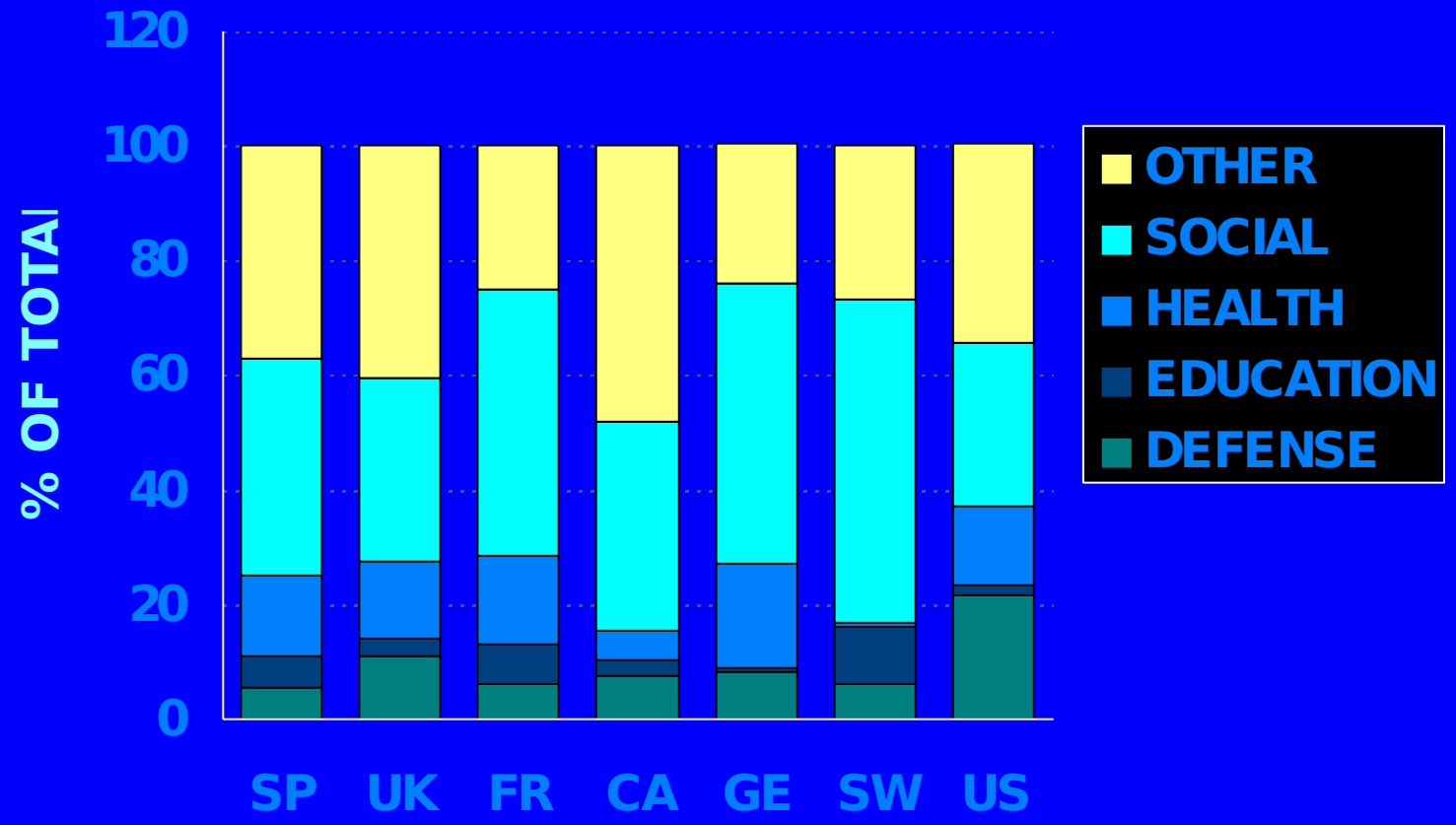


OECD HEALTH DATA 97

AHRQ

Comparative Healthcare Systems

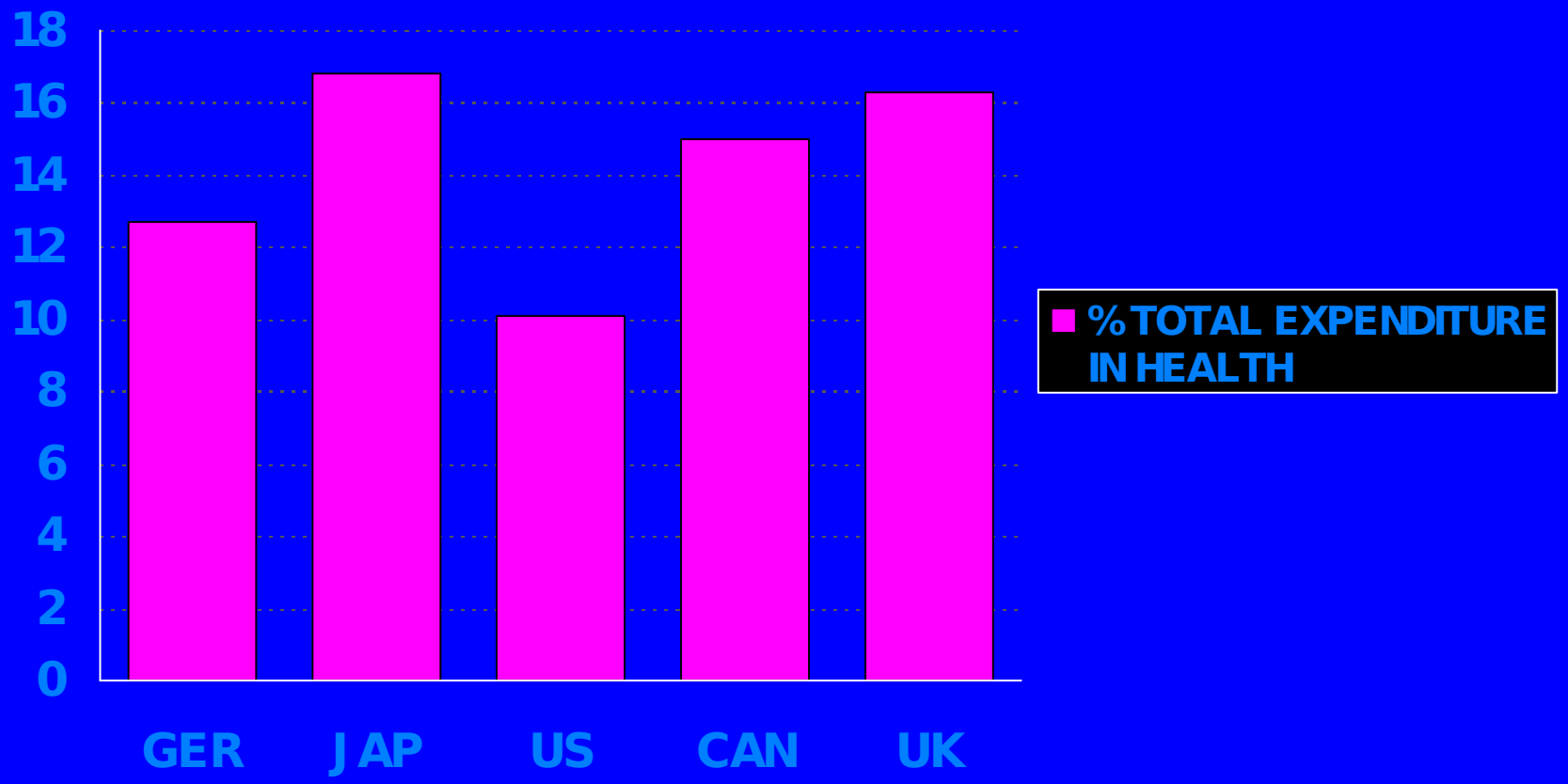
Central Government Expenditures



WORLD BANK DATA (1991)

AHRQ

Comparative Healthcare Systems
Expenditures on Pharmaceuticals



OECD HEALTH DATA 2001

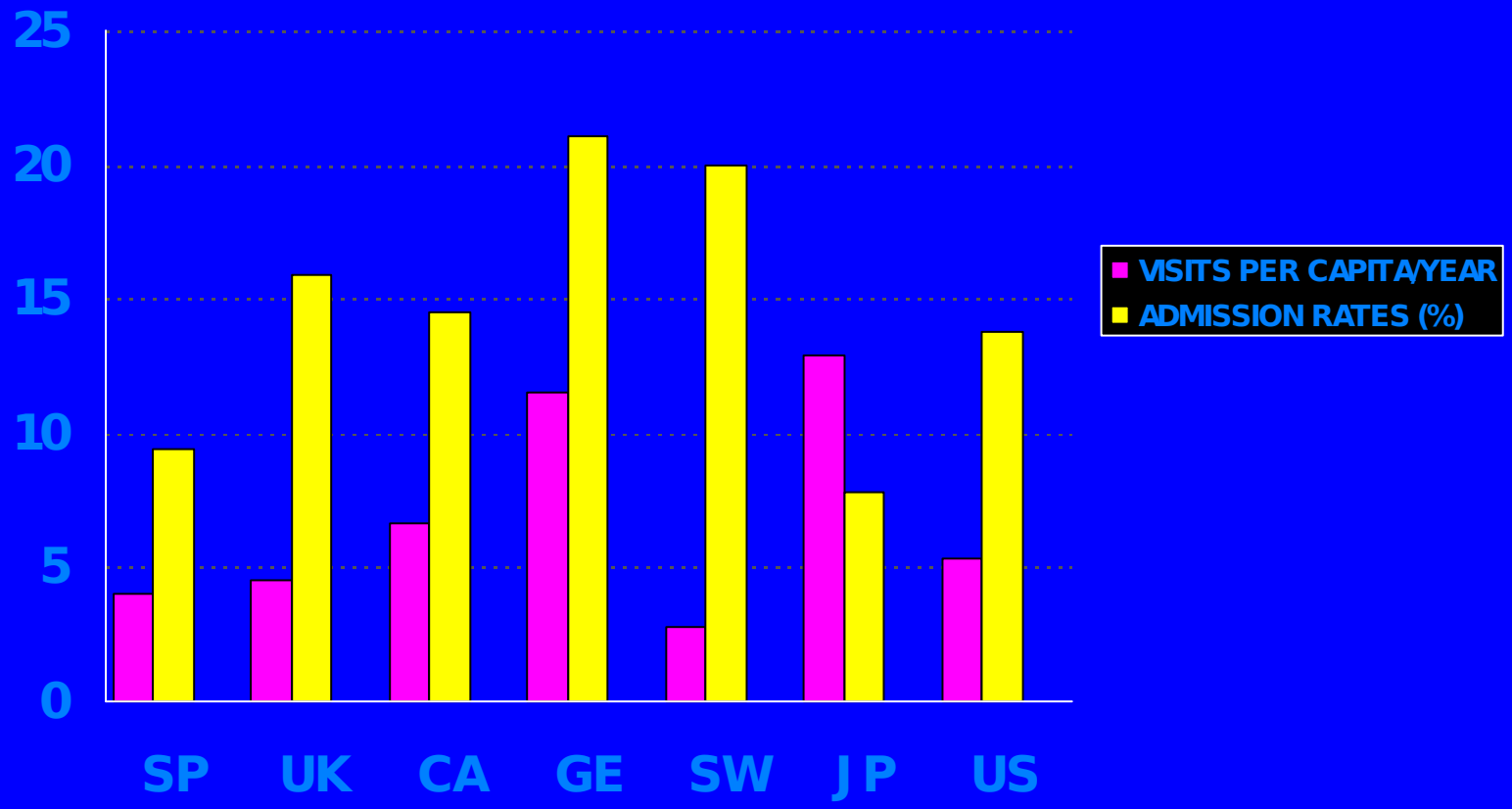
AHRQ

Japanese Drug Reform

- Physicians prescribe and dispense medication allowing high profit margins
- Unique ability for physicians to negotiate directly with pharmaceutical companies
- Reform aimed to reduce gap between reimbursement and wholesale cost
- Instead, an increase in prescriptions and use of more expensive drugs; expenditures increased

Comparative Healthcare Systems

Process Measures



WORLD BANK DATA

Distribution of direct costs by disease categories (17 chapters of the ICD 9-CM) as percentage of total direct costs

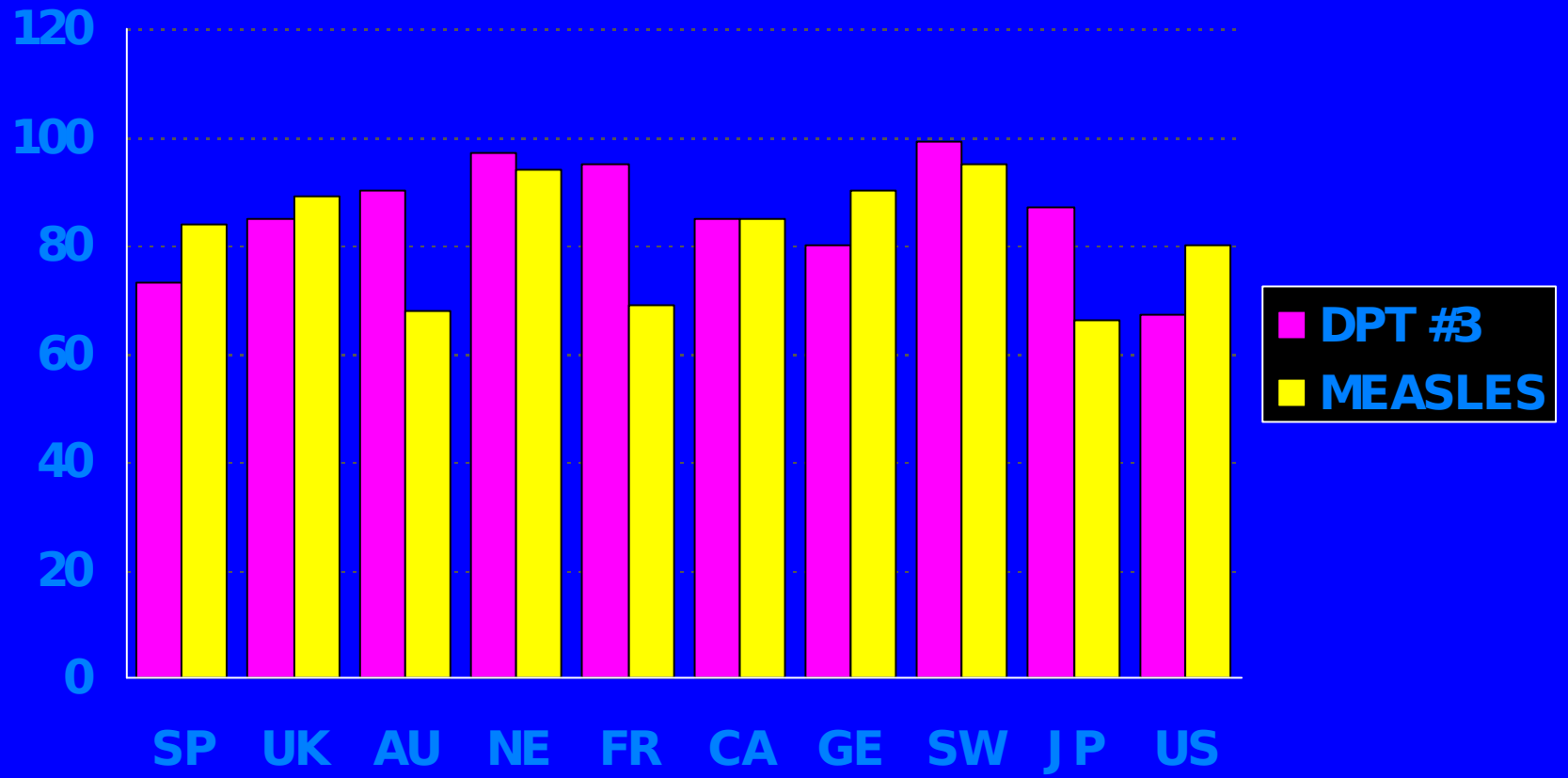
Disease category (ICD-Chapters)	US%	Sweden %	The Netherlands %
Blood diseases	0.4	0.5	0.3
Congenital diseases	0.5	0.5	0.4
Perinatal diseases	n/a	0.5	0.9
Diseases of the skin	2.5	1.7	0.9
Infectious diseases	1.8	1.6	1
Endocrine disorders	3.1	2.3	1.7
Genitourinary diseases	5.1	3	2.7
Pregnancy	n/a	2.7	3.5
Nervous system diseases	7.1	4.2	3.8
Accidents, poisoning, violence	7.7	4.8	4.3
Respiratory diseases	7	5	3.1

Distribution of direct costs by disease categories (17 chapters of the ICD 9-CM) as percentage of total direct costs (cont.)

Disease category (ICD-Chapters)	US%	Sweden %	The Netherlands %
Symptoms	1.6	5.1	4.3
Neoplasms	5.5	5.1	4.6
Digestive system diseases	12.9	3.8	7.6
Locomotor diseases	5.5	3.9	7
Cardiovascular diseases	13.6	12.3	8.7
Mental disorders	8.3	21.1	19.9
Others	3.2	0	0
Not allocated	14.2	21.9	25.2
Total	**100**	**100**	**100**

Comparative Healthcare Systems

Immunization Rates (Age >1)

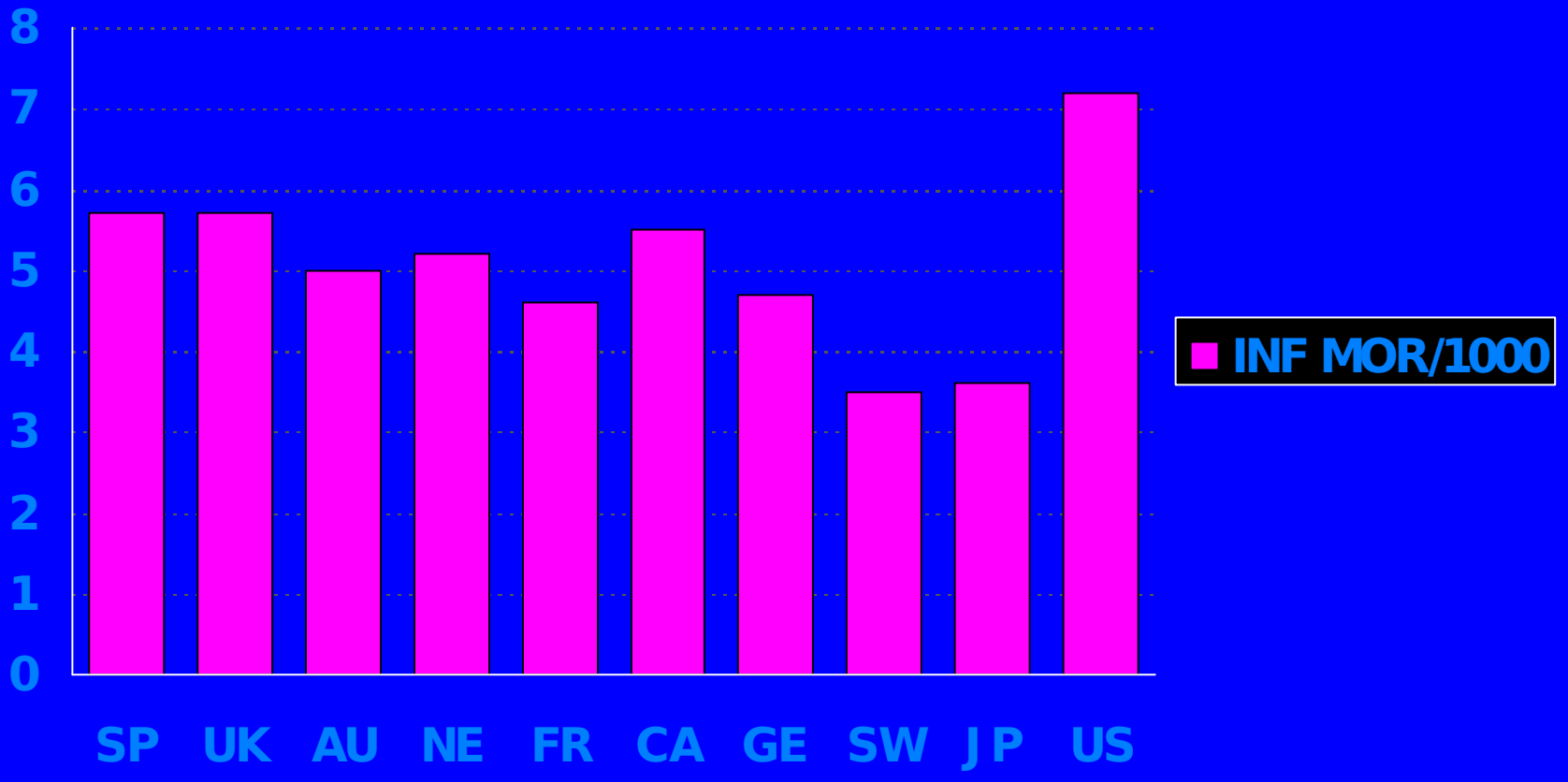


WORLD BANK DATA

AHRQ

Comparative Healthcare Systems

Selected Outcomes



OECD HEALTH DATA 2001

* Data on Canada 1997

All other Data

Health outcome measures, 1997

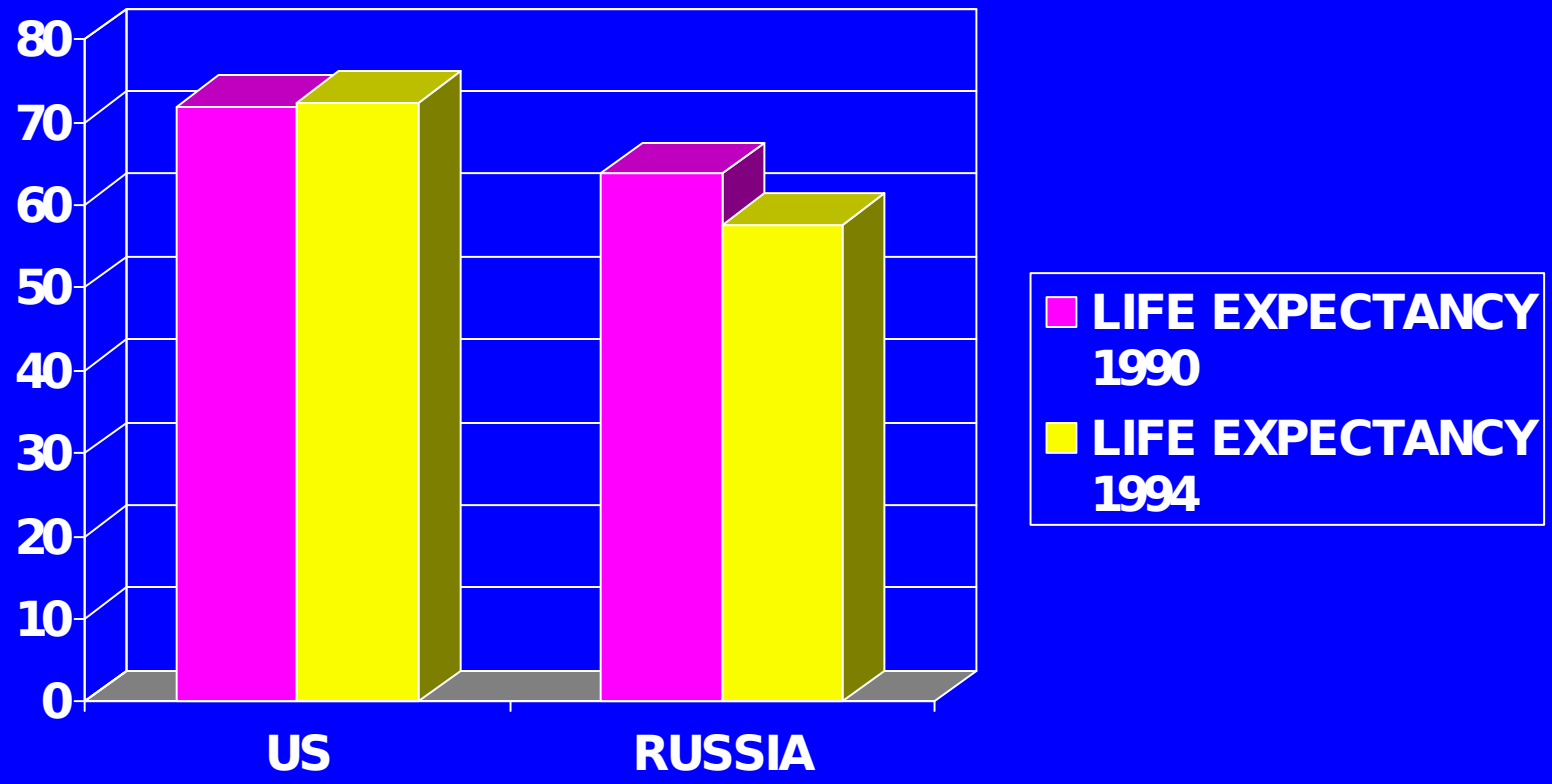
	Infant mortality*	Life expectancy at birth		Life expectancy at age 80	
		Men	Women	Men	Women
Germany	4.8	74.1	80.3	6.8	8.3
United Kingdom	5.9	74.6	70.7	6.7	8.5

*per 1000 live births

OECD Health Data 2001

AHRQ

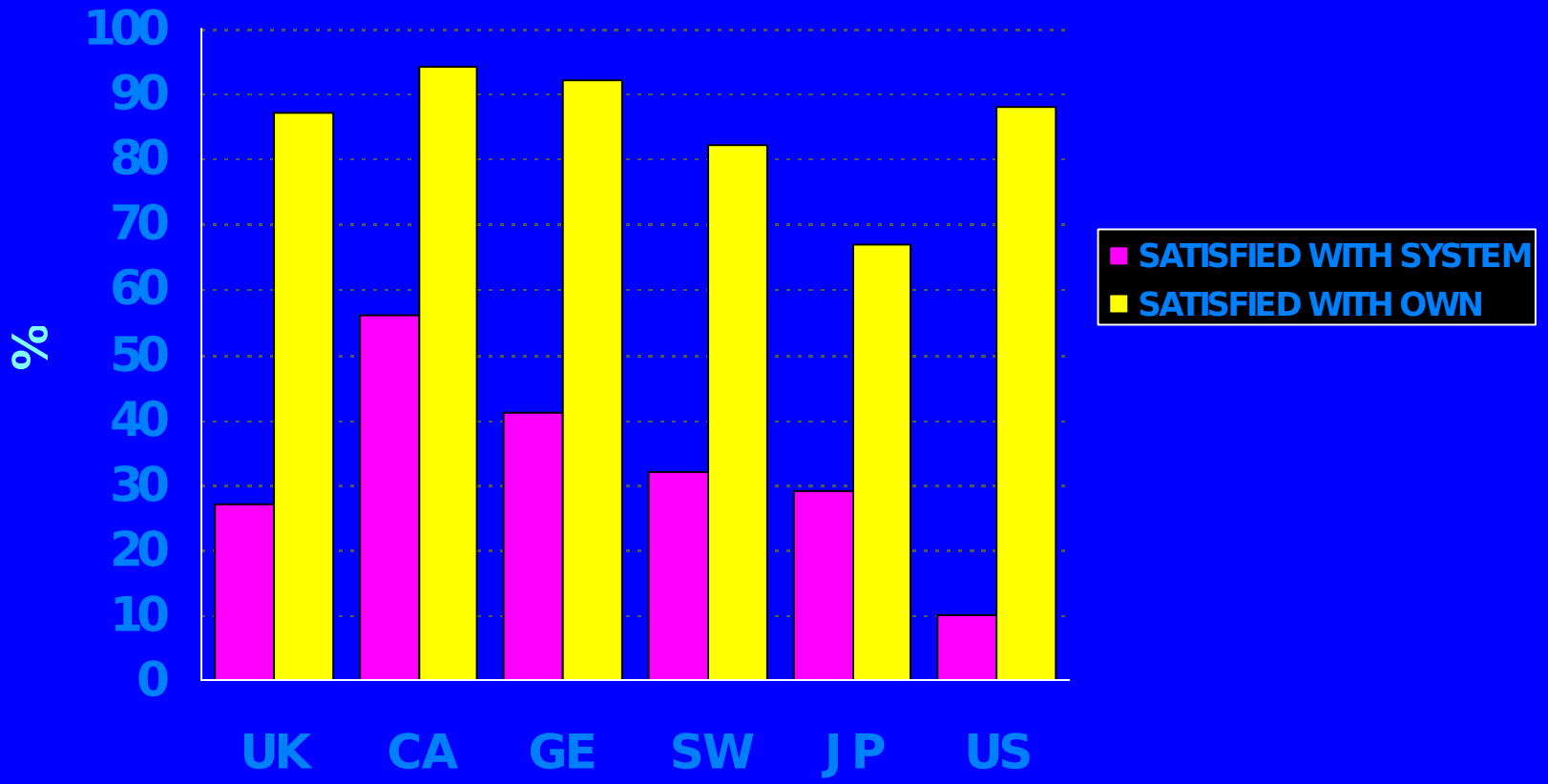
The Fourth Horseman?



'98 6 11

Comparative Healthcare Systems

Satisfaction with Care



WORLD BANK DATA

AHRQ

Medical Education and Specialization

- ***Germany*:** specialization governed by state medical councils
- ***UK*:** strict regulations on number of specialists
- ***Sweden*:** national board of health and welfare allocates slots to counties for specialist training

AHRQ

Medical Education and Specialization

- ***Canada:*** regulation of all specialties is concentrated in provinces
- ***France:*** fee structure provides incentives for generalist physicians relative to specialists
- ***US:*** fee structure provides incentives for specialist physicians relative to generalists

AHRQ

Priority Setting in Norway

Priority	Criteria	Examples
ZERO	High demand, dubious effectiveness	cosmetic surgery, , screening where there is no increased risk of disease
First	Acute life threatening	Trauma, severe infectious disorders, acute psychiatry, obstetric complications
Second	Life threatening or evoking severe disability in the medium/ long term	Severe chronic disorders, pregnancy surveillance, child development surveillance
Third	Services supported by evidence on effectiveness	Treatment of moderate hypertension, varicose veins, child immunization, occupational medicine and health promotion
Fourth	Services in high demand but mixed evidence on effectiveness	Routine ultrasound scanning of pregnant women, in vitro fertilization, spa visits without rehabilitation

AHRQ

Managed care

Preconditions for quality

Disease management strategy

Input

- Epidemiology (needs)
- Demography
- Prioritisation

Tools

- Clinical guidelines protocols of care
- Education
- Doctors' compliance
- Patients' compliance
- Process management
- Integrated information systems

Output

Baseline outcomes

Quality/cost indicators

Best-in-class outcomes

Quality/cost indicators

Close this gap

Nationwide clinical databases for outcomes monitoring are currently being introduced in some countries, *e.g.* Denmark

AHRQ

National Quality Reports

- US
- UK
- Australia
- New Zealand
- Canada
- OECD (international)

WHO
World Health Report 2000

Health Systems: Improving Performance

- major shift from traditional infectious disease and prevention focus
- index of national health systems' performance in trying to achieve
  - **good health**
  - **responsiveness to populations expectations**
  - **fairness of financial contribution**

AHRQ

WHO
World Health Report 2000

Health Systems Functions

- service provision
- resource generation
- financing
- stewardship

Report available at www.who.int

Conclusions

- Different populations lead to different health systems
- History leaves an important legacy
- No universal "best" system
- When system is designed with incentives which reflect goals it will work

Other US Healthcare System Issues

- "To Err is Human..."
- "Chasm Report..."
- Quality/Patient Safety
- Responsiveness
- Public-Private Partnerships
- Globalize the Evidence-Localize the Decisonmaking

US Healthcare System Paradox

- Least universal, most costly
- High quality primary, specialty, hospital and technology services available
- Access spotty

Is this a problem?

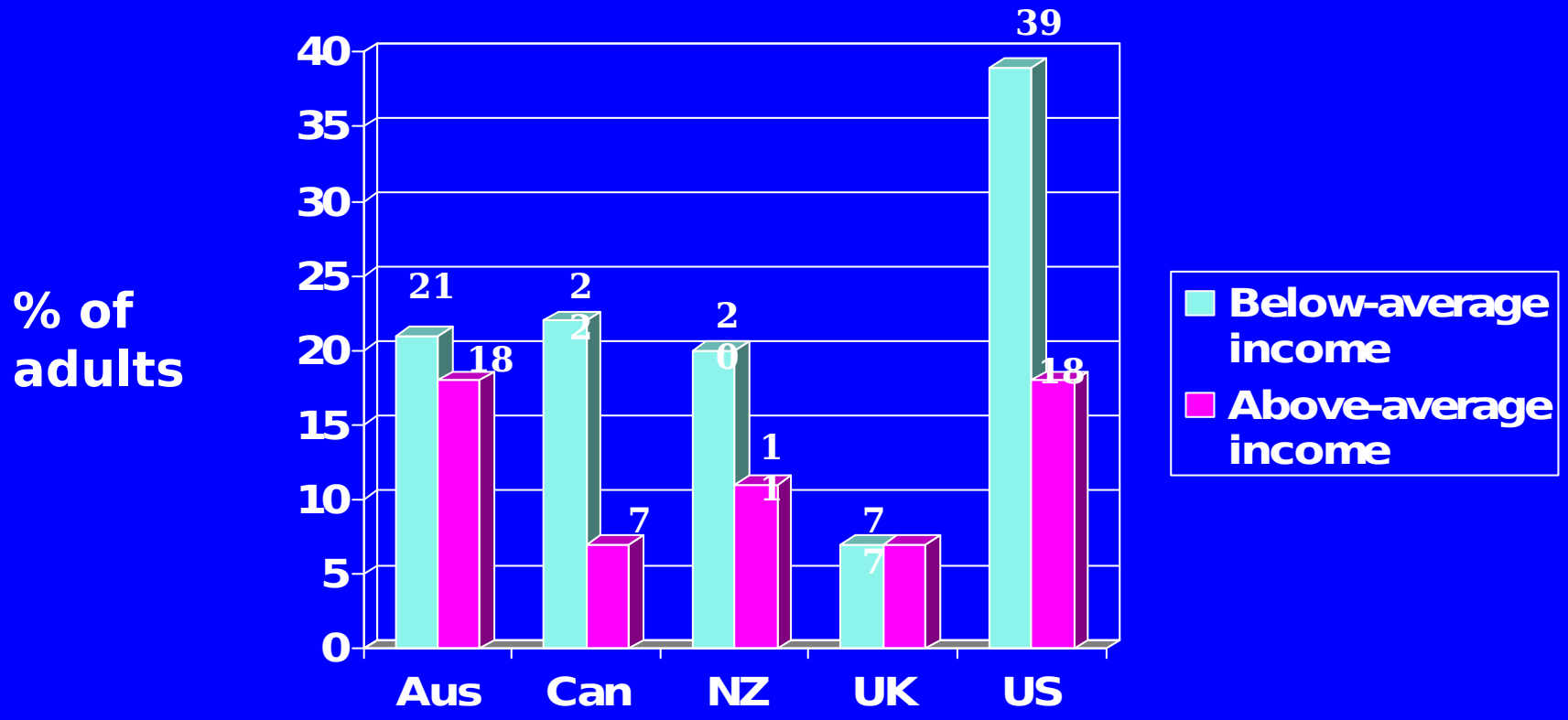
- 79 % of US adults believe the healthcare system needs to be rebuilt completely or fundamentally changed

- 29 % of US adults report a problem paying medical bills

Source: The Commonwealth Fund 2001 International Health Policy Survey

AHRQ

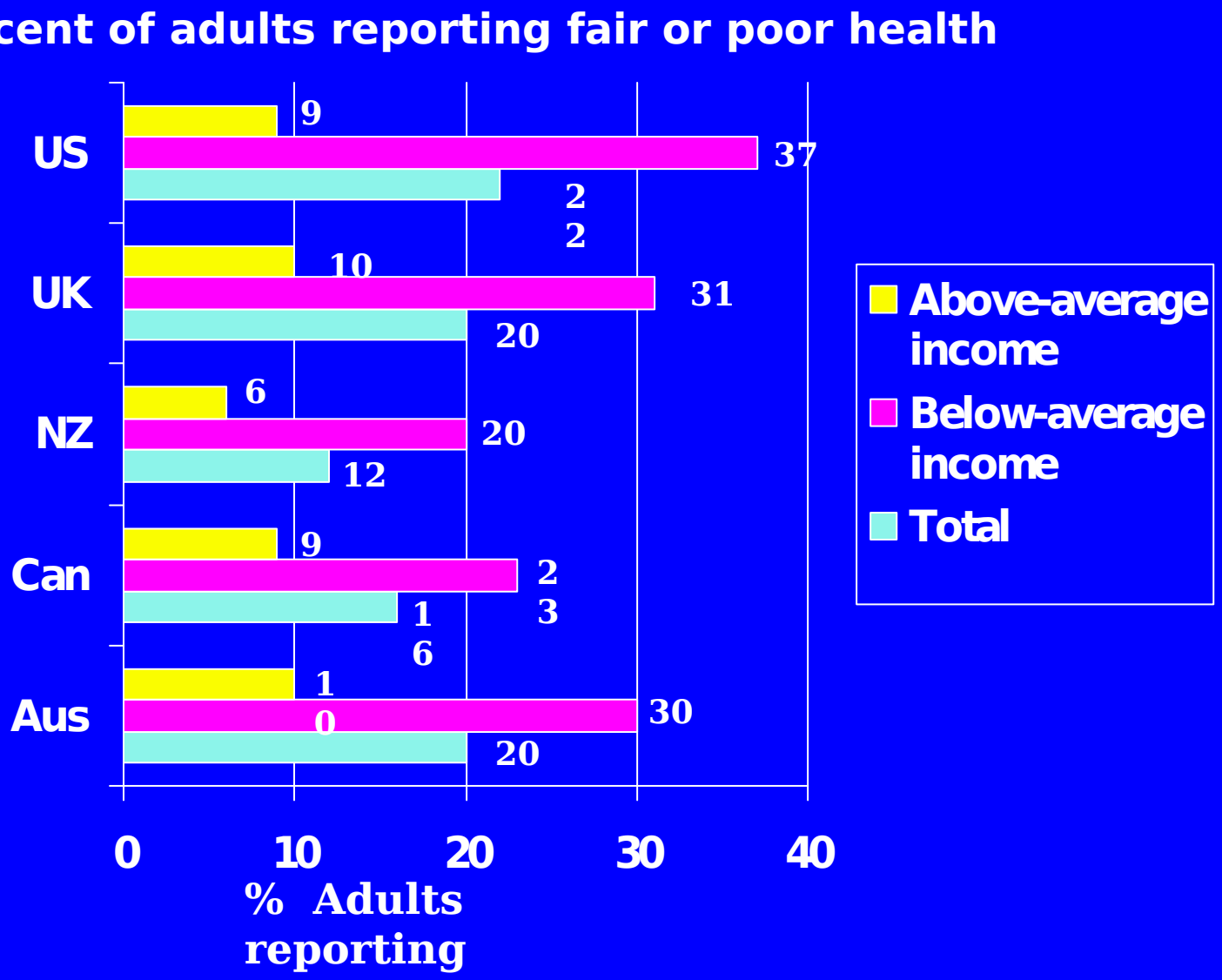
Cost in Past Year, by Income, 2001



Source: The Commonwealth Fund 2001 International Survey

AHRQ

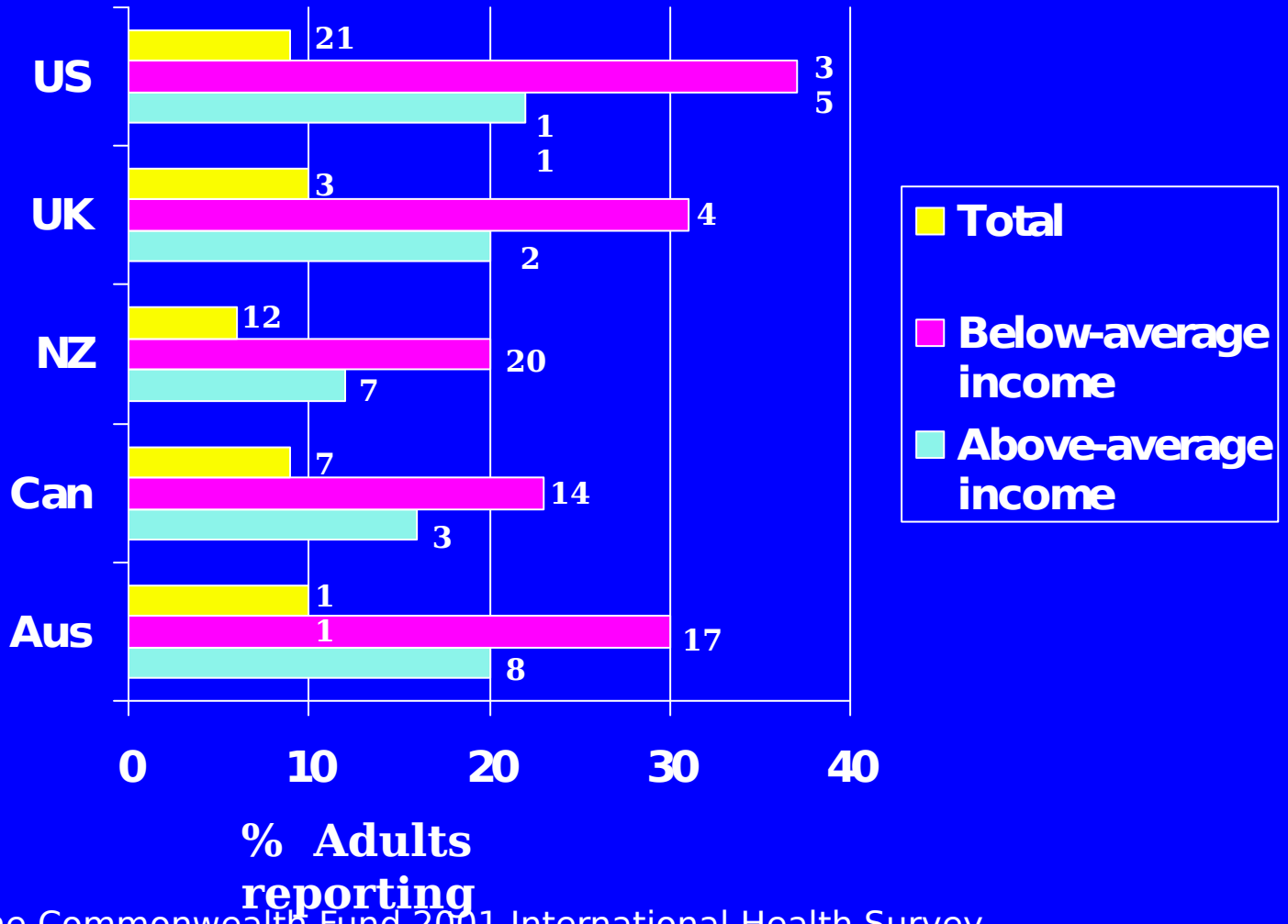
Health Status and Income, 2001



Source: The Commonwealth Fund 2001 International Survey

AHRQ

U.S. Adults Most Likely to Have Problems Paying Medical Bills, 2001



Source: The Commonwealth Fund 2001 International Health Survey

AHRQ

Comparative Healthcare Systems

Thank you

Deborah Queenan
Coordinator, International Health
Agency for Healthcare Research and Quality

www.ahrq.gov